MEDI-CAL UPDATE

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Program and Eligibility August 2003

Contents

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

HIPAA Transactions and Code Sets: Medi-Cal Implementation Plan Reminder and Update

This is the latest update and reminder in a series of articles regarding Medi-Cal's efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets Final Rule. Implementation is taking place in a series of phases, some of which will extend beyond the October 16, 2003 compliance date. Therefore, it is critical for providers to review their *Medi-Cal Update* over the coming months for detailed HIPAA billing instructions and training information. The September *Medi-Cal Update* will include many replacement pages regarding the changes.

Code Correlations

Medi-Cal developed code set correlation tables so providers, vendors and clearinghouses can prepare for business and billing operation changes and software and practice management system modifications. Correlation tables are separated by claim type and billing media (paper, current proprietary and non-standard formats and HIPAA standard formats). The tables reflect the correlation between the current code and the national code. The condition, delay reason, inpatient patient status, inpatient revenue and Place of Service code correlation tables were printed in the Part 1 section of the June *Medi-Cal Update*. The ICD-9-CM Volume 3 surgical code correlation table was printed in the Part 1 section of the July *Medi-Cal Update*. All of these tables can also be found on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking "HIPAA Update" and then "HIPAA Code Correlations."

Please see **HIPAA**, *page 3*

The energy challenge facing California is real. The Department of Health Services encourages practical and feasible energy saving measures while considering the health and safety of clients, workers and family members.

EDS/MEDI-CAL HOTLINES

Border Providers ..... **(916) 636-1000, ext. 2100**
Computer Media Claims (CMC) ..... **(916) 636-1100**
DHS Medi-Cal Fraud Hotline **1-800-822-6222**
Health Access Programs (HAP) – Cancer Detection Programs: Every Woman Counts, OB, CPSP and Family PACT Providers **1-800-257-6900**
POS/Internet Help Desk **1-800-427-1295**
Provider Support Center (PSC) **1-800-541-5555**
Provider Telecommunications Network (PTN) **1-800-786-4346**
Specialty Programs **1-800-541-7747**

For a complete listing of specialty programs and hours of operation, please refer to the Medi-Cal Directory in the provider manual.

MEDI-CAL FRAUD
IS AGAINST THE

LAW

MEDI-CAL FRAUD COSTS TAXPAYERS MILLIONS EACH YEAR AND CAN ENDANGER THE HEALTH OF CALIFORNIANS.

HELP PROTECT MEDI-CAL AND YOURSELF BY REPORTING YOUR OBSERVATIONS TODAY.

DHS MEDI-CAL FRAUD HOTLINE
1-800-822-6222

THE CALL IS FREE AND YOU CAN REMAIN ANONYMOUS.

Knowingly participating in fraudulent activities can result in prosecution and jail time. Help prevent Medi-Cal fraud.

HIPAA *(continued)*

Note: Updates to the Outpatient Place of Service correlation table will be published in September. Updates are as follows:

- Local Educational Agency (LEA) providers who currently bill with a Place of Service code "7" for outpatient services should bill with the national Place of Service code "89."
- Rehabilitation clinics that bill outpatient occupational therapy, speech therapy, acupunture, audiology and physical therapy services with a local Place of Service code "7" should bill the national Place of Service code "74."

Medicare/Medi-Cal Crossovers

Processing of electronically transmitted Medicare/Medi-Cal crossover claims currently remains the same, with the exception of a transaction standard modification. As billing procedures are modified, instructions will be provided in future *Medi-Cal Updates.* The requirement to bill provider-generated crossover claims on paper directly to Medi-Cal remains unchanged, although some code set values and Field Locators (FL) will change, as listed in the correlation tables published in the Part 1 section of the June *Medi-Cal Update.* All other billing instructions for Medicare/Medi-Cal crossover claims remain in effect.

The California Medicaid Management Information System (CA-MMIS) will be modified to capture the patient account number in an effort to comply with the HIPAA Transactions and Code Sets Final Rule regarding health plans, health care clearinghouses and health care providers who submit claim transactions electronically.

For Part-A Medicare crossover claims submitted via Medicare intermediaries, Medi-Cal is modifying the *Medical Record Number/Patient Account Number* field on the *Remittance Advice Details* (RAD) form and the *Medical Record Number* field on the Automated Remittance Data Services (ARDS) file. Currently, Medi-Cal records the medical record number submitted to Medicare by the provider. With the implementation of the X12N 837 Institutional format, the patient account number will be reported in the *Medical Record Number/Patient Account Number* field on the RAD and in the *Medical Record Number* field on the ARDS file.

For Part-B Medicare crossover claims submitted via Medicare carriers, Medi-Cal is modifying the *Medical Record Number/Patient Account Number* field on the RAD and the *Medical Record Number* field on the ARDS file. Currently on the RAD, Medi-Cal does not report the patient account number submitted to Medicare by the provider. The ARDS file contains the Medicare Insurance Claim Number (ICN) in the *Medical Record Number* field. With the implementation of the X12N 837 Professional format, the patient account number will be reported in the *Medical Record Number/Patient Account Number* field on the RAD and in the *Medical Record Number* field on the ARDS file.

Admit Type on Outpatient Claims

For dates of service on or after September 22, 2003, providers must bill the Admit Type (FL 19 on paper claim and CL101 on the 837 V4010A1 Institutional) of "1" (Emergency) when billing for outpatient emergency services.

Type of Bill

For dates of service on or after September 22, 2003, Inpatient Services providers and providers billing on the *UB-92 Claim Form* for outpatient services must enter the appropriate *Type of Bill* on UB-92 paper claims. Providers should no longer include the Place of Service in FL 50. For providers who submit using the ASC X12N 837, Version 4010A1 Institutional format, the *Type of Bill* is required. The *Type of Bill* values can be obtained from the *National Uniform Billing Committee (NUBC) UB-92 Billing Manual.*

Please see **HIPAA**, *page 4*

HIPAA *(continued)*

Billing Limit Exception on Paper Claims (Vision, LTC, HCFA 1500, UB-92)
The HIPAA-mandated national delay reason code that replaces Medi-Cal's billing limit exception code is two characters. Effective for dates of service on or after September 22, 2003, Medi-Cal will only accept the national delay reason codes as outlined in the ASC X12N 837 Version 4010A1 implementation guide. This data must be submitted in the following fields on the paper claims:

- Medical Services and Allied Health (HCFA 1500): Box 24J.
- Inpatient and Outpatient Services (UB-92): FL 31. The billing limit exception code was previously submitted in condition code fields 24-30.
- Long Term Care (25-1): Boxes 11, 30, 49, 68, 87 and 106. The two-character delay reason code may not fit in these boxes since the original box on the claim form was created as a single-character field. In cases where a two-digit delay reason code is needed, the first digit should be entered to the left of the one-digit box.
- Vision Care (45-1): Box 9. The two-character delay reason code may not fit in this field since the original box on this claim form was created as a single-character field. In cases where a two-digit delay reason code is needed, the data overflow may occur to the left or right of the one-digit box.

Place of Service for Subacute Facilities
On Medical Services claims, Medi-Cal currently uses local code values "91" (Subacute Care) and "96" (Pediatric Subacute Care) to differentiate between recipients who reside in an adult or pediatric subacute facility. For dates of service on or after September 22, 2003, providers must bill national Place of Service code 99 in Box 24B in conjunction with modifier "HA" to indicate pediatric and "HB" to indicate adult. These modifiers must be submitted with every procedure code on the claim. When Medi-Cal policy requires additional modifiers be billed with a specific procedure, then the "HA" or "HB" modifier must be entered in the last used modifier field.

On outpatient claims, Medi-Cal currently uses local code values "F" (Adult Subacute Care) and "M" (Pediatric Subacute Care) to differentiate between recipients who reside in an adult or pediatric subacute facility. For dates of service on or after September 22, 2003, providers must bill national *Facility Type* "27" in FL 4 in conjunction with modifier "HA" to indicate pediatric and "HB" to indicate adult. These modifiers must be submitted with every procedure code on the claim. When Medi-Cal policy requires additional modifiers be billed with a specific procedure, then the "HA" or "HB" modifier must be entered in the last used modifier field.

Billing Vision Qualifier Codes on the ASC X12N 837 Professional Version 4010A1
Beginning September 22, 2003, Vision Care providers may begin billing their claims on the ASC X12N 837 Professional Version 4010A1 format. The vision qualifier codes must be billed in the first modifier field of the SV101 segment (SV101-3). The current draft of the Vision Care Companion Guide erroneously states that the vision qualifier code may be placed in any available modifier fields. This will be updated in a future draft.

Obstetrical Billing on Inpatient Claims
Providers currently bill local accommodation codes 085 (nursery acute without associated delivery) and 095 (nursery acute with associated delivery). For claims with a "From Statement Covers Period" date on or after September 22, 2003, providers must bill national revenue code 172 (nursery, newborn, Level II) instead of code 085 or 095. To distinguish a claim with a delivery from one without a delivery, providers must bill the appropriate obstetrical related ICD-9-CM Volume 3 procedure code when there is a delivery. For appropriate codes, see the ICD-9-CM Volume 3 surgical code correlation table.

Please see **HIPAA**, *page 5*

HIPAA *(continued)*

Service/Procedure Code Sets
Medi-Cal's service/procedure code correlation table (for inpatient revenue codes) and policy and billing code changes (for Chiropractic, Orthotics and Prosthetics, and Immunizations and Vaccines) were included in the June *Medi-Cal Update* and are also posted on the Medi-Cal Web site. Correlation tables will not be developed for Chiropractic, Orthotics and Prosthetics, and Immunizations and Vaccines code sets and associated modifiers because one-to-one correlations of interim (local) to national codes are not applicable for these groups. These specific code values are effective for dates of service on or after September 22, 2003 for all billing media and all Medi-Cal (fee-for-service) and public health program areas. There is no transition (grace) period.

The conversion of the remaining interim (local) codes to national service/procedure codes will be implemented in phases and effective based on date of service. All other interim code values remain in effect and will be used for billing purposes until providers are instructed otherwise. These changes will be announced in a future *Medi-Cal Update*.

Remittance Advice (Health Care Claim Payment/Advice) for all Claim Types (ASC X12N 835)
As previously published, Medi-Cal will begin generating the ASC X12N 835 transaction beginning October 1, 2003 for claims adjudicated on or after September 22, 2003. Providers who elect to receive an electronic remittance advice in the ASC X12N 835 standard format can download the remittance advice from the Internet Bulletin Board System (IBBS) beginning October 1, 2003.

The ASC X12N 835 transaction enrollment process began July 21, 2003. An ASC X12N 835 transaction receiver must be an authorized Computer Media Claims (CMC) submitter or have a valid *Medi-Cal Point of Service (POS) Network/Internet Agreement* on file. Authorized providers are required to complete and sign the new *Electronic Health Care Claim Payment/Advice Receiver Agreement* form (included in the June *Medi-Cal Update*) before they can receive ASC X12N 835 transactions from Medi-Cal or designate a receiver for 835 transactions. This form was added to the end of the *Remittance Advice Details (RAD): Electronic* section of the Medi-Cal provider manual and on the forms page of the Provider Relations Organization Web site (**pro.medi-cal.ca.gov/forms.asp**). Completed agreement forms must be sent to the address provided on the form in order to be processed. Providers will be notified when their enrollment is completed or if there is a problem with their application.

Enrollment Process
The following steps detail Medi-Cal's enrollment process:

For New Enrollment:
Download the *Electronic Health Care Claim Payment/Advice Receiver Agreement* form from the Medi-Cal Web site or make a copy of the form from the provider manual. Be sure the form and revision numbers (DHS 6246, 5/03) are present and legible.

1. Complete all boxes on the form.
2. Sign and date the form on page 6.
3. Mail to the address provided on page 6.

Note: The *Electronic Health Care Claim Payment/Advice Receiver Agreement* form also may be used to update or cancel a previous agreement.

Please see **HIPAA**, *page 6*

HIPAA *(continued)*

For Additions:
If the update regards an addition of a receiver:

1. Check the "Change" box on page 1 and the second box on page 6.
2. Complete all boxes on page 1.
3. Indicate "Add" in the receiver information section on page 2, next to the words "Receiver #1."
4. Complete the required information for the added receiver.
5. Sign and date the form on page 6.
6. Mail to the address provided on page 6.

For Deletions:
If the update regards a deletion of a receiver:

1. Check the "Change" box on page 1 and the second box on page 6.
2. Complete all boxes on page 1.
3. Indicate "Delete" in the receiver information section on page 2, next to the words "Receiver #1."
4. Complete the required information for the deleted receiver.
5. Sign and date the form on page 6.
6. Mail to the address provided on page 6.

For Both an Addition and a Deletion:
If the update regards both an addition and deletion of a receiver:

1. Check the "Change" box on page 1 and the second box on page 6.
2. Complete all boxes on page 1.
3. Indicate "Add" in the receiver information section on page 2, next to the words "Receiver #1."
4. Complete the requested information for the receiver to be added.
5. Indicate "Delete" next to the words "Receiver #2."
6. Complete the requested information for the receiver to be deleted.
7. Sign and date the form on page 6.
8. Mail to the address provided on page 6.

For Cancellations (No Longer a Receiver of 835 Transactions):

1. Check the "Cancel" box on page 1 and the third box on page 6.
2. Complete all boxes on page 1.
3. Sign and date the form on page 6.
4. Mail to the address provided on page 6.

Providers will receive an acknowledgement letter within two weeks from the time the *Electronic Health Care Claim Payment/Advice Receiver Agreement* form was submitted. If the agreement form cannot be processed, it will be returned to the provider with a letter explaining the error(s) made on the form. Provider testing is not required prior to receiving ASC X12 835 transactions on the Medi-Cal Web site. To check the status of their receiver agreement form, in-state providers can call the Provider Support Center (PSC) at 1-800-541-5555 and select prompt option "4" and out-of-state providers and software vendors can call (916) 636-1000.

Note: When a provider enrolls to receive an 835 transaction, the provider can choose to discontinue receipt of the paper RAD.

Please see **HIPAA**, *page 7*

HIPAA *(continued)*

Testing and Activation Procedures

Testing and activation for X12N 837 transactions began July 23, 2003. Computer Media Claims (CMC) and paper claims must meet the same edit and audit requirements based on Medi-Cal billing policy. Participation as a CMC submitter is open to all Medi-Cal providers. The acceptable media submission types are dial-up, tape or Internet (**www.medi-cal.ca.gov**). For specific information regarding requirements for each media submission type, refer to the *Medi-Cal CMC Billing and Technical Manual*. The proper formats are the X12N 837 Institutional and Professional Version 4010 A1.

A signed *Medi-Cal Telecommunications Provider and Biller Application/Agreement* is required from CMC submitters prior to testing and activation of the X12N 837 V4010A1 format. All submitters must sign a new agreement form to be activated for the X12N 837 V4010A1. Billing services submitting electronic claims must complete the biller portion of the form. Providers for whom the billing service submits claims must complete the provider portion of this form. It is not necessary for the active billing service/clearinghouse to submit an application/agreement for each of its existing providers. Application/agreement forms from physicians and physician groups must contain the group provider number and the signature of an authorized physician within the group. Individual providers who bill with the group number do not need to submit separate provider application/agreement forms.

Once enrollment is complete, submitters must send a test file to the CMC Unit. Test submissions should contain a cross section of claim type data that can be expected in a production environment and consist of a minimum of 10 claims for each claim type to be billed. A maximum of 100 claims is allowed for testing. Files exceeding that limit are subject to rejection. Submitters should use data from previously adjudicated claims, as claims contained on the test file will not be processed for payment. Any format problems discovered during the testing period must be corrected and a new test file submitted for review prior to the final approval. Questions should be directed to the CMC Help Desk at (916) 636-1100.

Submitters may test for multiple media using the same submitter number. Once approval is received for each medium, submitters may use the same submitter number for all media. Billing services already tested and approved are not required to retest for each provider as long as they use the same approved CMC submitter number, format, medium and claim types. A new application/agreement form is still required for all new providers.

X12N 837 health care claim transactions may be submitted through the CMC system for providers who bill Long Term Care, Inpatient Services, Outpatient Services, Medical Services, Vision Care and Allied Health claim types. The X12N 837 transaction record format is described in the appropriate companion guide on the Medi-Cal Web site. Click on "HIPAA Update" and then "Draft HIPAA ASC X12N and NCPDP Technical Specifications." Data elements included in a submission are either required for X12N 837 standard transactions or Medi-Cal claims processing.

The test telephone number is (916) 638-8127. Submitters using the CMC TelePoint telecommunications system should perform a protocol test before submitting test data. Additional information is available in the telecommunications submission section in the *Medi-Cal CMC Billing and Technical Manual*.

Please see **HIPAA**, *page 8*

HIPAA *(continued)*

Submitters are notified of format infractions by one of the following methods:

- Submitters with access to the Medi-Cal test Web site (**sysdev.medi-cal.ca.gov**) can log in through the "Transaction Services" link to view their error reports and files submitted.
- Submitters without Internet access will receive a call from the CMC Help Desk each time an error is encountered. Submitters may call the CMC Help Desk at (916) 636-1100 for help correcting submission errors.

Note: The entire 837 CMC submission will be rejected if the *Receiver ID* is not "610442" and all claims on a transaction are not processed.

Approximately two weeks after the tests are processed, submitters receive a CMC test approval or denial letter with the test results via regular postal mail. The test results also include a review of field data formatting specifications. This review is not a requirement for CMC submission approval. It is meant to assist in preventing claim denial due to format specification errors.

Test tapes should be labeled according to the instructions in the CMC tape submission section of the *Medi-Cal CMC Billing and Technical Manual.*

Mail CMC test tapes to:

EDS Corporation
CMC Unit
P.O. Box 15508
Sacramento, CA 95852-1508

Send CMC test tapes delivered by courier to:

EDS Corporation
CMC Unit
3215 Prospect Park Drive
Rancho Cordova, CA 95670-6017

EDS must approve each CMC submitter for electronic claim submission of the new X12N 837 format. For new submitters and providers, EDS will notify the Department of Health Services (DHS) upon completion of the testing process. DHS will then place the submitter in "Active" (production) status and will send the provider and/or billing service a letter authorizing CMC submission. The letter will include the name(s) of the providers/billers authorized to submit claims.

Technical Specifications/Companion Guides
The Medi-Cal ASC X12N 837 Institutional and Professional companion guides are available on the Medi-Cal Web site by clicking "HIPAA Update" and then "Draft HIPAA ASC X12N and NCPDP Compound Specifications."

Frequently Asked Questions
Medi-Cal developed a HIPAA Frequently Asked Questions section of the Medi-Cal Web site, which can be accessed by clicking "HIPAA Update" and then "HIPAA Frequently Asked Questions." Providers are encouraged to check the Web site regularly for updates. For more information about HIPAA and Medi-Cal's implementation plan, call PSC at 1-800-541-5555 and select prompt option "4."

Note: The September mailing of the *Medi-Cal Update* may be split due to the high volume of replacement pages generated by the HIPAA implementation.

OPT OUT: Monthly Electronic *Medi-Cal Updates*

The new OPT OUT service enables providers to receive monthly electronic notification (e-mail) with direct, customized links to current *Medi-Cal Updates*, manual pages and training information on the Medi-Cal Web site. Links tailored to provider communities make it easier for providers to decide which Medi-Cal information is relevant to the services they render and conveniently print that information in their own offices, as needed. Providers who enroll in OPT OUT will no longer receive *Medi-Cal Updates* in hard copy (printed) format.

Enrollment is simple. Providers must have a valid e-mail address and complete a short *OPT OUT Enrollment Form,* which can be downloaded from the Medi-Cal Web site (**www.medi-cal.ca.gov**). For more information, contact the Provider Support Center (PSC) at 1-800-541-5555.

CERTS Software: Discontinued September 22, 2003

The Claims and Eligibility Real-Time System (CERTS) will be discontinued effective close of business September 22, 2003. (Pharmacy claims on CERTS were deactivated in October 2002.) All transactions previously available using the CERTS software (eligibility, batch eligibility, Share of Cost, Share of Cost Reversal, Medi-Services, Medi-Services reversal and HCFA 1500/837) are available through the Medi-Cal Web site (**www.medi-cal.ca.gov**).

With this change, the Medi-Cal manual section *CERTS Software* is no longer applicable and should be removed. If you have questions, call the POS/Internet Help Desk at 1-800-427-1295. Manual pages reflecting this information will be released in a future *Medi-Cal Update.*

POS Device (Verifone Omni 3300) Software Upgrades

Effective immediately and continuing indefinitely, Medi-Cal will download several patches and software upgrades to new Verifone Omni 3300 POS (Point of Service) devices. Downloads will occur primarily between 6 p.m. and 6 a.m. weekdays. To accommodate the downloads, leave the POS device turned on and at the "Welcome to Medi-Cal" screen. (The electrical draw is negligible.) When a download is completed, "System" option is the only prompt available. To reactivate the transaction menus, perform a test transaction. Information on performing test transactions is found in the in the *Device System Transactions* section of the *POS Device User Guide*. For additional help, call the POS/Internet Help Desk at 1-800-427-1295, seven days a week from 6 a.m. to midnight.

Billing for Newborn Services: Update

Policy related to Medi-Cal coverage of services for a newborn during the first two months of life, when the mother's medical services are limited or restricted, has been clarified. A mother's Medi-Cal Benefits Identification Card (BIC), whether for restricted or full-scope benefits, can be used to bill full-scope medical services rendered to her newborn during the month of delivery and the following month.

This information is reflected on manual replacement pages elig rec crd 4 (Part 1) and percent 2 and 10 (Part 1).

WIC Supplemental Nutrition Program: Infant Formula Update

Effective August 1, 2003, the California Women, Infants and Children (WIC) Supplemental Nutrition Program implemented a new infant formula rebate contract to provide the following standard formulas:

- Similac® Advance (milk-based)
- Similac® with Iron (milk-based)
- Similac® Isomil Advance (soy-based)
- Similac® Isomil with Iron (soy-based)
- Similac® Lactose Free

Providers are encouraged to inform parents that the new standard formulas are very similar to those offered under the previous rebate contract and that changing formulas will not adversely affect the infant's health. Any discomfort experienced by the infant as a result of the new formula will be temporary (3–5 days) and in most cases, mild.

Infants with qualifying medical conditions may be eligible for medically prescribed formulas through Medi-Cal if they are enrolled in a Medi-Cal Fee-for-Service/Managed Care (FFS/MC) program. WIC may temporarily provide medically prescribed formulas to infants who have not yet completed the Medi-Cal enrollment process. Infants who are ineligible for Medi-Cal may obtain medically prescribed formulas through WIC if they have a prescription stating medical justification and can verify Medi-Cal ineligibility. Gastro-intestinal formulas that are not currently Medi-Cal benefits may be provided by WIC if an infant has a prescription stating medical justification that is renewed every three months.

Note: WIC does not receive manufacturer rebates for non-standard, non-contract cow milk and soy-based formulas.

WIC actively supports breastfeeding and any formulas provided by WIC are not intended to compete with breastfeeding.

Managed Care: Drug Updates

PLEASE RETAIN THIS ARTICLE FOR FUTURE REFERENCE

AIDS Drug
Effective for dates of service on or after March 13, 2003, the AIDS drug enfuvirtide (Fuzeon) is a noncapitated drug for specific Managed Care Plans (MCPs) and Partnership HealthPlan of California-CMSP, Health Care Plan (HCP) 530, a County Medical Services Program pilot program.

Selected Anti-Psychotic Drugs
Effective for dates of service on or after May 1, 2003, selected anti-psychotic drugs are noncapitated for County Organized Health System (COHS) Partnership HealthPlan of Solano, HCP 504.

Please see **Managed Care**, *page 11*

Managed Care *(continued)*

Anti-Psychotic Injection Procedure
Effective for dates of service on or after May 1, 2003, anti-psychotic injection ziprasidone mesylate (Geodon injectable) (HCPCS X7498) is noncapitated for the following plans:

County	County Code	Health Care Plan (HCP)	HCP Number	Plan Type
Monterey	27	Central Coast Alliance for Health	508	COHS
Napa	28	Partnership Health Plan of CA	507	COHS
Orange	30	CalOptima	506	COHS
Sacramento	34	Molina Healthcare of California	130	GMC
Sacramento	34	Health Net	150	GMC
Sacramento	34	Blue Cross of California	190	GMC
San Francisco	38	Family Mosaic Project	601	SP/TCM
Santa Cruz	44	Central Coast Alliance for Health	505	COHS
Solano	48	Partnership HealthPlan of California-CMSP	530	CMSP 2-year Pilot/COHS
Yolo	57	Partnership HealthPlan of CA	509	COHS

Please retain this article for future reference until the release of the provider manual replacement pages in a future *Medi-Cal Update*.

www.medi-cal.ca.gov

AEVS Other Health Coverage Carrier Codes: August Updates

The *AEVS: Other Health Coverage Carrier Codes* list has been updated. Providers should refer to the complete *AEVS: Other Health Coverage Carrier Codes* list on the Medi-Cal Web site at **www.medi-cal.ca.gov**. These codes are updated monthly and are accessible by clicking the "Publications" link, the appropriate "Provider Manual" link and the "Online-Only Section" link. Additions and changes are shown in bold and underlined type.

Providers may order a hard copy update of the section by calling the Provider Support Center (PSC) at 1-800-541-5555. Updates are listed below.

Code	Carrier	Code	Carrier
B123	BLUE CROSS OF IDAHO	F259	FOUNDATION HEALTH DENTAL
B136	BLUE CROSS BLUE SHIELD OF MO	L079	LIFEGUARD
D227	DELTA HEALTH SYSTEMS	U049	UNION ROOFERS HWTF

www.medi-cal.ca.gov

Medi-Cal Suspended and Ineligible Provider List: August Updates

The *Medi-Cal Suspended and Ineligible Provider List* (S&I List) is updated monthly and is available on the Internet at **www.medi-cal.ca.gov**. Additions and changes are shown in bold type and reinstated providers are removed from the S&I List. Always refer to the S&I List when verifying provider ineligibility.

Please see the S&I List by clicking the "Publications" link, the appropriate "Provider Manual" link and then the "Online-Only Section" link on the Medi-Cal Web site. Providers may view or download the S&I List in Microsoft Word format. Providers may also order a hard copy update of the section by calling the Provider Support Center (PSC) at 1-800-541-5555.

Physicians (susp A)

Cooper, Richard Paul 234 Hybiscus Avenue, No. 168 Lauderdale by the Sea, Florida	G65857 03/03/03.	Suspended indefinitely effective
Fernabach, Louise Oftedal 11 Orchard Road Charlottesville, Virginia	G1649	Suspended indefinitely effective 05/01/02.
Greenson, Daniel Peter 2340 Ward Street, Suite 101 Berkeley, California	A21872	Suspended indefinitely effective 02/14/03.
Hubbell, David V. 10800 Paramount Boulevard, No. 406 Downey, California	A15713	Suspended indefinitely effective 02/11/03.
Kirkham, Dan R. 17220 Newhope, No. 293 Fountain Valley, California	G11339	Suspended indefinitely effective 06/04/03.
Malabed, Leonilo L. 145 Mountain Spring Avenue San Francisco, California	A16847	Suspended indefinitely effective 02/27/03.
Nourmand, Amir Daniel 1448 Beverwil Drive Los Angeles, California	G80075	Suspended indefinitely effective 02/26/03.
Phattiyakul, Pricha 10331 Southern MD Boulevard Dunkirk, Maryland	A37784	Suspended indefinitely effective 09/19/01.
Ratnam, Indran aka: Thurairatnam, Indran Rajpal 325 Carolwood Drive Henderson, Nevada		Suspended indefinitely effective 01/05/89.
Rivero, Evelyn C. Fountain Medical Clinic 4352 Fountain Avenue Los Angeles, California	A37002	Suspended indefinitely effective 06/04/03.
Robinson, Malcolm George 3900 North Harvey Parkway Oklahoma City, Oklahoma	C32809	Suspended indefinitely effective 08/08/02.
Sellers, Anthony Bruce 1371 West Cerritos Avenue, No. 83 Anaheim, California	G80081	Suspended indefinitely effective 08/01/02.
Thorp, Richard Hardy 6151 North Fresno, Suite 101 Fresno, California	G14937	Suspended indefinitely effective 03/05/03.
Wagner, Richard Stephen Route 2, Box 19 Cibola, Arizona	A33255	Suspended indefinitely effective 02/12/03.

Psychologist (susp C)

Farrell, Walter Michael 120 Ford Street Ukiah, California	PSY5603	Suspended indefinitely effective 10/20/02.
Powers, William Henry 1821 North Magellan Drive Santa Maria, California	PSY13619	Suspended indefinitely effective 09/20/02.

Sick Room Supplies (susp F)

Advance Medical Supply 4121 Pennsylvania Avenue Glendale, California	Suspended indefinitely effective 06/12/03.
AN&N Medical Supplies Mambreyan, Norayr 3129 ½ Glendale Boulevard Los Angeles, California	Suspended indefinitely effective 06/12/03.
Arrow Medical Supply Tersakyan, Khachatur 457 East Arrow Highway, Suite C Azusa, California	Suspended indefinitely effective 06/19/03.
G's Medical Supply Sogomonyan, Georgiy R. aka: Sogomonyan, George 1089 East Shaw Avenue, Suite 104 Fresno, California	Suspended indefinitely effective 06/25/03.
GNA Care Medical Supply Bagdarsarian, Maria 4682 York Boulevard, Suite F Los Angeles, California	Suspended indefinitely effective 06/12/03.
L.A.'s Star Orthopedics and Medical Supply Titizyan, Oganes 13653 Victory Boulevard Van Nuys, California	Suspended indefinitely effective 06/19/03.

Please see **S&I**, *page 13*

S&I *(continued)*

Lady Tiger Medical Supply Gasparyan, Anna 18408 Hatteras, Apartment 20 Tarzana, California		Suspended indefinitely effective 06/19/03.
Mother Teresa's Medical Supply Nazaryan, Tigran 2161 Colorado Boulevard, Suite 105 Eagle Rock, California		Suspended indefinitely effective 06/12/03.
Pico Central Medical Supply Karapetyan, Melkon Armen 5599 West Pico Boulevard Los Angeles, California		Suspended indefinitely effective 06/12/03.
SY Medical Supplies Yengibaryan, Sarkis 474 West Riverdale Drive, No. 202 Glendale, California		Suspended indefinitely effective 06/12/03.

Dentist (susp G)

Ward, Douglas Austin Garfield 4904 19th Street Lubbock, Texas	29518	Suspended indefinitely effective 06/21/02.

Acupuncturist (susp I)

Kwak, Choon Ja 4809 Firestone Boulevard South Gate, California	AC3850	Suspended indefinitely effective 10/20/02.
Spa Acupuncture/Acupressure 327 West Manchester Boulevard Inglewood, California		Suspended indefinitely effective 10/20/02.

Chiropractor (susp J)

Milkey, John Joseph 1720 Ximeno Avenue, Suite 8 Long Beach, California	DC11988	Suspended indefinitely effective 10/18/02.
Nguyen, Sandy L. 5916 Garbough Drive San Jose, California	DC21761	Suspended indefinitely effective 11/18/02.
Pham, Megan Loan 5962 Westminster Boulevard Westminster, California	DC27145	Suspended indefinitely effective 09/23/02.
Wassif, Anthony A. dba: North Hills Therapy Reseda Chiropractic and Health Therapy Massage La Brea Health Therapy Sunset Therapy Sunset Therapy Oriental Massage 8750 Sepulveda Boulevard, Suite C6 North Hills, California	DC0259960	Suspended indefinitely effective 10/07/02.

Podiatrist Clinics (susp K)

Shvartsman, Stanley M. 120 South Swall Drive, No. 212 Los Angeles, California	E2909	Suspended indefinitely effective 03/12/03.
Vihinen, Jeffrie M. 1940 16th Street, Apartment 0106 Newport Beach, California	E3801	Suspended indefinitely effective 08/19/02.

Physical Therapist (susp O)

Dollinger, David Leroy 101 East Highway 12 Lodi, California	PT7491	Suspended indefinitely effective 04/26/02.

Home Health Aide (susp P)

Keagy, Thera P.O. Box 1089 Cave Junction, Oregon		Suspended indefinitely effective 10/20/02.

Respiratory Care Practitioner (susp S)

Townsend, John Lawrence 2685 Westlake Drive Kelseyville, California	RCP7145	Suspended indefinitely effective 08/15/02.

Reinstatements

Fair Oaks Neck & Back Clinic 4944 Sunrise Boulevard, Suite A Fair Oaks, California		05/02/03.
Driver, Suzanne 4104 24th Street, No. 165 San Francisco, California	388260	02/25/03.
Safranko, Brenda Jean 2807 H Street Bakersfield, California		06/13/03.

Instructions for Manual Replacement Pages
Program and Eligibility — August 2003

Part 1

Remove and replace at the end of the *Point of Service (POS)* section:
Medi-Cal Point of Service (POS)Network/Internet Agreement
Point of Service (POS) Device Usage Agreement

Remove and replace:
aid codes 1/2, 15/16 *
elig rec crd 3/4
percent 1/2, 9/10

*Updated sections available at **www.medi-cal.ca.gov***

Automated Eligibility Verification System Carrier Codes for Other Health Coverage
Medi-Cal Suspended and Ineligible Provider List

*Updated Indexes and Glossary available at **www.medi-cal.ca.gov***

* Pages updated/corrected due to ongoing provider manual revisions.